Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 08/24/01, 11/02/01, and 12/14/01.
   b. The request was received on 03/08/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs/Medical Audit summaries
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFAs
   c. EOBs/ Medical Audit summaries
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14day response to the insurance carrier on 06/28/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/28/02. The response from the insurance carrier was received in the Division on 07/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/18/02
   "(Carrier) indicates that we did not support our services billed with the proper documentation. I disagree with them on their decision due to we have followed the TWCC fee guidelines for the aforementioned patient. We also showed documentation of what these services incurred for reconsideration….We have showed medical necessity in everything we do and that our Doctors [sic] are licensed to do these services."

2. Respondent: Letter dated 07/06/02
"Review of the office visit notes does not reveal a detailed examination, history, and medical decision making of moderate complexity….This carrier disagrees with the requester that all the key components necessary to bill a 99214 level office visit were documented….In conclusion, the level of service billed, 99214, for the dates of service in dispute is not documented or medically necessary. Additionally, the charge in dispute, 99214, appears to be requester's routinely charged level of office visit, not necessarily based on level of service that is medically necessary or rendered."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 08/24/01, 11/02/01, and 12/14/01.

2. Per the provider's TWCC-60, the amount billed is $213.00; the amount reimbursed is $0.00; the amount in dispute is $213.00.

3. The carrier denied the billed services by codes, "COD1 – F – T,N DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER CODE'S VALUE PER RULE 133.301 (B). A REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED."

4. The carrier submitted medical audits to the provider for dates of service dated 12/30/01 and 01/25/02 stating, "Reimbursement is denied for the service billed as the documentation submitted does not support the specific level of service billed as it is defined in the 1996 TWCC Medical Fee Guideline…"

5. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
08/24/01 11/02/01 12/14/01	99214 99214 99214	$71.00 $71.00 $71.00	$0.00 $0.00 $0.00	F,T,N	$71.00	MFG E/M GR (IV) (A); (C) (2); (VI) (B); STG Rule 134.1001 (e) (2) (A), (e) (2) (O); CPT descriptor	MFG E/M GR (IV) (A) introduces the levels of services which encompass wide variations of skill, effort, time, responsibility, and knowledge required to treat the diagnosis of claimant's illnesses and injuries. The services can include examinations, evaluations, treatments, counseling, and conferences with or concerning the patient. (IV) (C) (2) states, "**TWO OF THE THREE KEY COMPONENTS** shall meet or exceed the stated requirements to qualify for a particular level of E/M service: office…"

							CPT code 99214 descriptor states, "Office…visit for the evaluation and management of an established patient, (reference MFG E/M VI B) which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity…..Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family." The STG Rule 134.1001 (e) (2) (A) specifically states that treatment of a work related injury must be: "(i) adequately documented (ii) evaluated for effectiveness and modified based on clinical changes (vi) objectively measured and demonstrated ongoing progress in the recovery process by appropriate re-evaluation of the treatment." STG Rule 134.1001 (e) (2) (O) establishes that "All health care providers treating an injured employee are responsible for substantiating in their documentation the level of service for which they request reimbursement." The provider submitted medical documentation supporting that services were rendered for all three dates of service. For date of service 08/24/01, the medical documentation is lacking two of the three key components required to document adequately; a detailed history, a detailed examination, a medical decision making of moderate complexity with a presenting problem of moderate to high severity. There is no history and no examination. The PLAN says "The patient will be started on a more aggressive exercise program…Re-check in about one month with X-rays." The provider failed to objectively measure any functional gains or ongoing progress in the patient's treatment or evaluate the treatment for effectiveness and modify treatment based on clinical changes. The level of care is not documented in the doctor's notes for 08/24/01. Documentation does not meet the criteria for CPT code 99214. For date of service 11/02/01, the medical documentation does include a physical exam and a plan, but the documentation does not meet the criteria of the 99214 CPT code descriptor of a detailed examination or medical decision making of moderate complexity of a presenting problem of moderate to high severity. The provider failed to objectively measure any ongoing progress in the patient's treatment. The PHYSICAL EXAM states, "He is ambulating well at this date. He is doing much better at the present time." The PLAN states, "The patient will be scheduled for a repeat lumbar MRI. He will return to the office in one month and we will re-x-ray his back at that time." The provider failed to adequately document the level of service required to evaluate for the effectiveness of the treatment and modify the treatment based on clinical changes. Date of service 12/14/01, the medical documentation includes a Past Medical History, a Physical Exam, and a Plan.. The Medical History and Physical Exam do not meet the criteria of the 99214 CPT code descriptor. The Plan does not present a medical decision making of moderate complexity for a presenting problem of moderate to high severity. There is inadequate documentation of evaluation of treatment for effectiveness or that treatment was modified based on clinical changes.

							The treatment plan was not objectively measured for functional gains or ongoing progress in the patient's treatment process. The provider failed to indicate the level of service in the documentation for date of service. The provider lacked documentation indicating the presenting problem was a level of service for a moderate to high severity. No reimbursement is recommended.
Totals		$713.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 1st day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm